CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING ASSISTED LIVING SERVICES PROVIDER

A participating assisted living services provider must meet the Virginia Department of Social Services (VDSS) licensing standards, must meet the standards and requirements set forth by the Virginia Department of Medical Assistance Services (DMAS), and must have a current, signed participation agreement with DMAS.

There is a two-tiered licensing system in assisted living facilities (ALFs): residential care and assisted living.

This chapter specifies the requirements for approval to participate as a Medicaid provider of assisted living services in an ALF. Any provider contracting with DMAS to provide services agrees as part of the provider participation agreement to adhere to all the policies and procedures in this provider manual.

DMAS will contract only with ALFs licensed by VDSS to provide assisted living services. All ALFs contracting with DMAS must be in compliance with VDSS licensure requirements for assisted living facilities (22 VAC 40-71-10 *et seq.*) and must ensure that all applicants and residents have been assessed in accordance with the VDSS assessment and case management regulations (22 VAC 40-745-10 *et seq.*).

REQUESTS FOR PARTICIPATION

Requests for applications for assisted living services provider participation must be addressed to:

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

An application for provider status and information regarding provider participation requirements and standards will be mailed to any interested party who requests information or application to become a Medicaid-approved provider and who meets the basic requirements for participation.

DMAS will send the potential provider two copies of a participation agreement for review and signature. (A copy of a participation agreement is included in "Exhibits" at the end of this chapter.) The provider must complete the identifying information, check the assisted living service(s) the provider will be performing, and sign and return both copies to FIRST HEALTH Services Provider Enrollment Unit. The provider must not make any alterations

to the contents of the agreement. At the same time, the provider must submit a copy of the assisted living license which was received from VDSS.

Once the signed copies of the participation agreement and the copy of the assisted living license from VDSS are received, DMAS will complete the other sections, including the effective date of the agreement (item #12) and will return one signed original to the provider.

GENERAL REQUIREMENTS

Each provider approved for participation in the Medical Assistance Program as an assisted living services provider must perform the following activities as well as any other specified by DMAS:

- Immediately notify DMAS, in writing, of any changes in the level of care authorized and the individualized service plan which the facility previously submitted to DMAS;

- Ensure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other facility qualified to perform the service(s) required and participating in the Medicaid Program at the time the service(s) are performed;

- Ensure the recipient's freedom to reject medical care and treatment;

- Accept referrals for services only when staff is available to deliver the required services;

- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.

- Provide to recipients services and supplies of the same quality and in the same mode of delivery as provided to the general public;

- Charge DMAS for the provision of services to recipients in amounts not to exceed the provider's usual and customary charges to the general public;

- Accept DMAS payment from the first day of the recipient's eligibility;

- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

  Example: If a third party payer reimburses $5 of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the recipient, a spouse, or a responsible relative.

  The provider may not bill DMAS or recipients for broken or missed appointments;

- Use Program-designated billing forms for submission of charges;

- Comply with the record maintenance and retention requirements:

  a. The facility agrees to maintain and keep adequate and verifiable information and records as are necessary to:

     i) Identify and disclose the extent of services, as identified on the Uniform Assessment Instrument (UAI) that the facility furnishes to recipients;
     ii) Comply with the disclosure requirements of Subpart B of Title 42 of the Code of Federal Regulations (42 CFR §§ 455 et seq.);
     iii) Assure proper payment by DMAS;
     iv) Receive payments under the Medicaid Program;
     v) Satisfy and secure overpayments made under the Medicaid Program; and
     vi) Survive any termination of the provider participation agreement;

  b. The facility agrees to furnish the information required to be maintained to DMAS, the Attorney General of Virginia or his authorized representatives, or the State Medicaid Fraud Control Unit on request and in the form requested. This right of access to facilities and records shall survive any termination of the provider participation agreement;

  c. Records shall be retained for at least five years from the last date of service or as provided by applicable state laws, whichever period is

longer. If an audit is initiated within the required retention period, the records shall be retained until the audit is completed and every adjustment, retraction, exception, and appeal is resolved; and

d. In the event a facility discontinues operation, DMAS shall be notified in writing of the location and procedures for obtaining stored records for review. The location, agent, or trustee shall be located within the Commonwealth of Virginia;

- Disclose all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid;

- Hold confidential and use for authorized DMAS purposes only all medical and identifying information regarding recipients served. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public; and

- Offer a choice of facilities. Recipients eligible for assisted living services shall be informed at the time of the assessment of all available assisted living facilities in the community and shall have the option of selecting the facility.

Advance Directives

At the time of their admission to services, all assisted living services providers participating in the Medicare and Medicaid programs must provide adult recipients with written information regarding an individual's right to make medical care decisions as outlined in this section. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a witnessed instruction, usually a document such as a living will or durable power-of-attorney for health care, recognized under state law and relating to the provision or withholding of care or treatment when the individual is incapacitated, comatose, or mentally or physically incapable of communicating. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, assisted living services providers must:

- Provide all adult individuals with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives;

- Inform recipients about and provide copies of the provider's written policy on implementing advance directives;
- Document in the recipient's medical record whether he or she has signed an advance directive;
- Not discriminate against an individual based on whether he or she has executed an advance directive; and
- Provide staff and community education on advance directives.

PROVIDER PARTICIPATION STANDARDS

In addition to the above, to be enrolled as a Medicaid assisted living services provider and maintain provider status, an ALF must meet the following requirements.

Maintenance of Good Standing with VDSS Division of Licensing Programs

The ALF must be in good standing with the VDSS Division of Licensing Programs and in compliance with the VDSS licensure requirements for assisted living facilities (22 VAC 40-71-10 *et seq*.). DMAS and VDSS will share information on facilities which are not in compliance with program requirements of either state agency.

Change of Ownership

When ownership of the facility changes, DMAS must be notified within 15 calendar days of such change. A new DMAS provider agreement will be required.

PROVIDER IDENTIFICATION NUMBER

Upon receipt, approval, and signature, of the signed contracts by DMAS, a provider identification number will be assigned. The provider will be sent a copy of the contract and the assigned provider identification number. **DMAS will not reimburse the provider for any services rendered prior to the effective date of this provider identification number and the receipt of this number in writing by the provider.** This number must be used on all billing invoices and correspondence submitted to DMAS.

REVIEW OF PROVIDER PARTICIPATION AND RENEWAL OF CONTRACTS

Providers are continuously assessed to assure conformance with VDSS and Medicaid participation standards and policies. VDSS Division of Licensing shall be responsible for monitoring each assisted living services provider's adherence to licensure standards which provide the basis for DMAS provider participation standards. In addition, DMAS shall periodically conduct audits of the services billed to DMAS and interview recipients to ensure that services are being provided and billed in accordance with DMAS policies and procedures. A facility's non-compliance with DMAS policies and procedures shall result in a written request from DMAS for a corrective action plan which details the steps the facility will take and the length of time required to achieve full compliance with DMAS

regulations, policies, and procedures. The corrective action plan must be approved by DMAS.

The provider is assessed on its ability to render consistent, high-quality care to a population that is in need of assisted living services. Information used by DMAS to make this assessment may include a DMAS desk review of documentation submitted by the facility and the case managers from the local public human service agencies, as well as on-site review of provider files and interviews with staff and with recipients and their families during visits to the assisted living facilities and via responses to quality assurance survey letters. The DMAS assessment of the provider is based on a comprehensive evaluation of the provider's overall performance in relation to the following Program goals:

1. Recipients served by the provider must meet the Program's target population. The ALF has a responsibility to be aware of the criteria for residential and assisted living level of care and, on an ongoing basis, to evaluate recipients' appropriateness for services accordingly. The ALF must terminate services for any recipient whose condition does not meet criteria or contact a public case management agency to perform another assessment to determine whether a change in level of care is warranted;

2. Services being rendered must meet the recipient's identified needs, as documented on the Uniform Assessment Instrument (UAI) and must be within the Program's guidelines. The ALF is responsible for continuously assessing the recipient's needs and updating the Individualized Service Plan (ISP) as needed;

3. The ALF documentation must support all days of assisted living services billed to DMAS; and

4. Services must be of a quality that meets the health and safety needs and the rights of the individual. Quality of care is best assured through an emphasis on communication and respect between the recipient and the ALF staff. Some of the elements included in quality of care are:

    - Consistency of Care: The degree to which the recipient receives services consistently from staff familiar with the recipient's needs and ISP. The ALF should strive to address consistency of care with staff and discuss with recipients ways to minimize the effects of staff turnover.

    - Continuity of Care: The degree to which the recipient receives services continuously according to the ISP.

    - Adherence to the ISP: It is the provider's responsibility to provide services according to the amount and type needed and to maintain a current ISP. Any difficulties in meeting the ISP must be documented in the recipient's record.

- Health and Safety Needs of the Recipient: The provider must identify any health and safety issues and communicate those to appropriate family members, the licensed health care professional and other agencies, etc., as well as follow up to see that these issues get resolved. This includes the provider's responsibility to identify any special needs of the recipient and to refer the recipient to service providers to meet those needs.

DMAS will review the provider's performance in all the Program goal areas to determine the provider's ability to achieve high quality of care and conform to DMAS policies. A DMAS analyst is responsible for providing feedback to the provider regarding those areas which may need improvement. Providers will receive periodic on-site reviews.

During on-site reviews, the DMAS analyst will review recipient files and conduct visits with recipients to assess the quality of care and continued appropriateness of assisted living services.

DMAS will communicate in writing with all providers following the on-site review to identify strengths and any areas in which improvement is needed.

DOCUMENTATION REQUIRED - RECIPIENT RECORDS

The assisted living provider must maintain a record for each recipient. These records will be reviewed periodically by DMAS staff for each assisted living resident. At a minimum, these records must contain:

- All Virginia Uniform Assessment Instruments (UAIs); Long-Term Care Preadmission Screening Authorization forms (DMAS-96); Assisted Living Facility Eligibility Communication Documents, and Individualized Service Plans completed for the recipient. These forms must be maintained for a period of not less than five years from the recipient's start of care in the ALF. Appendix C contains copies of these forms; and

- All written communication related to the provision of care between the facility and the assessors, case manager, licensed health care professionals, DMAS, VDSS, the recipient, or other related parties. This may include, but is not limited to, staffing notes regarding contacts made with the recipient or others regarding the recipient's care. Other contacts may be with family, physician, DMAS, or other professionals.

The facility must also maintain a log which documents each day the recipient is present in the facility. This log should be kept at a central location at the facility. This log must be completed on a daily basis. Leave of Absence Logs (LOAL) which document a resident's absence may not be used in lieu of daily recipient logs to document the presence of a resident in the facility.

RECIPIENT RIGHTS AND RESPONSIBILITIES

As provided in § 63.1-182.1 of the Code of Virginia, the assisted living services provider must establish written policies and procedures to ensure that, at a minimum, each person who becomes a resident of the assisted living facility is fully informed, prior to or at the time of admission and during the resident's stay, of his or her rights and responsibilities. The statute further states that the residence must provide a copy of these rights to each resident and must include in them the name and telephone number of the VDSS regional licensing supervisor, the Virginia Long-Term Care Ombudsman Program, and the Department for the Rights of Virginians with Disabilities.

As a DMAS provider, the Recipient's Rights/Responsibilities Statement must also include the following notification concerning complaints:

"The DMAS (Medicaid) pays (provider name) to provide (type of service) to you. If you have a problem with these services, you should contact DMAS at (804) 225-4222 or submit your written comments to:

DMAS – Facility and Home Based Services Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219"

ADULT PROTECTIVE SERVICES

Adult protective services (APS) are provided through the VDSS Adult Services Program. Services are provided to prevent abuse, neglect, or exploitation of an adult or a person with a disability. This includes an investigation to determine the need for protective services and provision of those activities, resources, and supports necessary to detect, reduce, prevent, or eliminate abuse, neglect, or exploitation. Services are provided across all long-term care settings including ALFs. Certain persons are mandated by the Code of Virginia to report all incidents of abuse, neglect, or exploitation to the local department of social services APS unit. Mandated reporters include persons licensed to practice medicine or any of the healing arts, persons employed in the nursing profession, and persons employed by a public or private agency or facility working with adults. Reports of alleged abuse, neglect, or exploitation should be made to the local department of social services' APS unit or to the statewide, 24-hour toll-free hotline at 1-888-83ADULT.

MEDICAID STAFF TO CONTACT WHEN QUESTIONS ARISE

When assisted living providers have questions regarding level-of-care decisions, distribution of forms, or DMAS policies and procedures concerning assisted living services in ALFs, they should contact the designated utilization review analyst in their specific regions. A list of regional offices is included below. If the analyst in the region is unavailable, the provider may contact the Facility and Home Based Services Unit, in the DMAS Central Office, at (804) 225-4222.

Central Region: Long-Term Care and Quality Assurance Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
(804) 225-4222

Southwest Region: Long-Term Care and Quality Assurance Division
Department of Medical Assistance Services
Commonwealth Building, Suite 330
210 Church Avenue
Roanoke, Virginia 24011
(540) 857-7342

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act, as amended (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider is responsible for making provision for disabled individuals in his or her program activities.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided the DMAS Director and FIRST HEALTH-Provider Enrollment Unit (FH-PEU) thirty (30) days prior to the effective date. The addresses are:

Director
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

First Health
VMAP-PEU
PO Box 26803
Richmond, Virginia 23261-6803

804-270-5105 or 1-888-829-5373 (in state toll-free), fax – 804-270-7027

DMAS may terminate a provider from participating upon thirty (30) days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to customers subsequent to the date specified in the termination notice.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

Section 32.1-325(c) of the Code of Virginia mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify DMAS of this conviction and relinquish the agreement. Reinstatement will be contingent upon provisions of state law.

REPAYMENT OF IDENTIFIED OVERPAYMENTS

Pursuant to § 32.1-325.1 of the Code of Virginia, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When a lump sum cash payment is not made, interest will be added on the declining balance at the statutory rate, pursuant to § 32.1-313.1 of the Code of Virginia. Interest will not apply pending appeal. Repayment schedules must ensure full repayment within 12 months.

RECONSIDERATION AND APPEALS OF ADVERSE ACTIONS

Non-State-Operated Provider

The following procedures will be available to all non-state operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement and denial of payment for services rendered based on utilization review decisions.

The reconsideration and appeals process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days to submit information for written reconsideration and will have a 30 day notice to request the informal conference and/or the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§ 9-6.14:1 through 9-6.14:25 of the Code of Virginia)(the APA) and the State Plan for Medical Assistance provided for in § 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the APA.

Any legal representative of a provider must be duly licensed to practice law in the Commonwealth of Virginia.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action such as termination or suspension of the provider agreement or denial of payment for services rendered based on utilization review decisions. State-operated

provider means a provider of Medicaid services which is enrolled in the Medicaid Program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration for any issue which would be otherwise administratively appealable under the State Plan by a non-state-operated provider. This is the sole procedure available to state-operated providers.

The reconsideration and appeals process will consist of three phases: an informal review by the Division Director, review by the Director of DMAS, and Secretarial review. First, the state-operated provider must submit written information to the appropriate DMAS Division specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives its Notice of Amount of Program Reimbursement, notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought; the amount of the adjustment sought; and the reasons for seeking the adjustment. The Division Director or his or her designee will review this information, requesting additional information as necessary. If either party so requests, they may meet to discuss a resolution. Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director will consider any recommendation of his or her designee and render a decision.

A state-operated provider may, within 30 days after receiving the informal review decision of the Division Director, request that the DMAS Director or his designee review the decision of the Division Director. The DMAS Director has the authority to take whatever measures he deems appropriate to resolve the dispute.

If the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, within 30 days after receipt of the decision of the DMAS Director, the provider may request the DMAS Director to refer the matter to the Secretary of Health and Human Resources or any other Cabinet Secretary as appropriate. Any determination by such Secretary or Secretaries will be final.

MEDICAID PROGRAM INFORMATION

Federal regulations governing program operations require Virginia Medicaid to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive provider manuals or Medicaid memoranda because he or she has access to the publications as a part of a group practice. To suppress the receipt of this information, the First Health Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803

Upon receipt of the completed form, FH-PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

EXHIBITS

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DO NOT WRITE IN SHADED AREAS. DO NOT ADD CONDITIONS TO THE AGREEMENT. WE DO NOT ACCEPT AGREEMENTS VIA FAX OR AGREEMENTS ON THERMAL PAPER.

Commonwealth of Virginia
Department of Medical Assistance Services
Medical Assistance Program

Adult Care Residence Assisted Living Services Participation Agreement

If re-enrolling, enter Medicaid Provider Number here→ _____ Check this box if requesting new number→ ☐

This is to certify:	PAYMENT/CORRESPONDENCE ADDRESS	PHYSICAL ADDRESS (*REQUIRED IF DIFFERENT FROM PAYMENT ADDRESS*)
NAME		
ATTENTION		
ADDR LINE 1		
ADDR LINE 2		
CITY, STATE, ZIP		

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

1. **The provider agrees to provide assisted living services (*checked below*) in accordance with all regulations, policies and procedures which govern the provision of service in an adult care residence. The provider is currently licensed and certified under applicable laws of the state and has been fully certified by the Department of Social Services to provide services. In addition, the provider agrees that all individuals providing services under this Agreement meet the criteria set forth in regulations and policy.**

_____Regular Assisted Living _____Intensive Assisted Living

2. **Services will be provided without regard to age, sex, race, color, religion, national origin or type of illness or condition. In accordance with the terms of Section 504 of the Rehabilitation Act of 1973, (29 U. S. C. § 794), no handicapped individual shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in VMAP.**
3. **The provider agrees to keep such records as VMAP determines necessary. The provider will furnish VMAP on request information regarding payments claimed for providing services under the State Plan. Access to records and facilities by authorized VMAP representatives and the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.**
4. **The provider agrees to care for patients at the current rate established by VMAP as of the date of service.**
5. **Payment made under VMAP constitutes full payment on behalf of the recipient except for patient pay amounts determined by VMAP, and the provider agrees not to submit additional charges to the recipient for services covered under VMAP. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a VMAP recipient for any service provided under VMAP is expressly prohibited and may subject the provider to federal or state prosecution.**
6. **The provider agrees to pursue all other health care resources of payment prior to submitting a claim to VMAP.**
7. **Payment by VMAP at its established rates for the services involved shall constitute full payment for the services rendered. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider shall reimburse VMAP upon demand.**
8. **The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended.**
9. **This agreement may be terminated at will on thirty days' written notice by either party or by VMAP when the provider is no longer eligible to participate in the program.**
10. **All disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.**
11. **The provider agrees, at all times, to retain full responsibility for any and all performance under this agreement, whether performed by the provider or others under contract to the provider.**
12. **This agreement shall commence on _____ and terminate on _____.**

For First Health's use *only*

Director, Division of Program Operations Date

IRS Name (required)

mail one completed original agreement to: **First Health - VMAP-Provider Enrollment Unit**
4461 Cox Rd. Suite 102
Glen Allen, VA 23060-3331

For Provider of Services:

Original Signature of Provider Date

_____City *OR* _____County of _____

IRS Identification Number (Area Code) Telephone Number

Medicare Carrier and Vendor Number

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

MAILING SUSPENSION REQUEST

Medicaid Provider Number: _____

Provider Name: _____

I do not wish to receive Medicaid memos, forms or manual updates under the Medicaid provider number given above because the information is available to me under Medicaid provider number

Provider Signature: _____

Date: _____

Please return this completed form to:

First Health Provider Enrollment Unit
P.O. Box 26803
Richmond, VA 23261-6803

VIRGINIA

Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia
23219

THIRD PARTY LIABILITY INFORMATION REPORT

(FOR MEDICAID PROVIDERS' USE)

This form MUST be submitted to the Department of Medical Assistance Services within 30 days after a service is rendered to a Virginia Medicaid recipient for the treatment of accident related injuries. Federal Regulations (42CFR - 433.138) require the Department of Medical Assistance Services to exert positive efforts toward locating liable third parties and to diligently seek refunds of applicable liability payments. Please complete this form to the best of your knowledge to assist us in this effort. Statutory authority is provided for full recovery of funds from liable third parties in Section 8.01-66.9 of the Code of Virginia.

PLEASE TYPE OR PRINT

NAME OF RECIPIENT: _____
(LAST) (FIRST) (MI)

RECIPIENT'S ELIGIBILITY NO. _____ DATE OF INJURY _____

TYPE OF ACCIDENT _____ DATE YOUR SERVICE BEGAN _____
(WORK, AUTO, HOME, GUNSHOT, ETC.)

NAME OF ATTORNEY _____

ADDRESS _____

(IF RECIPIENT HAS AN ATTORNEY, THE FOLLOWING INFORMATION IS NOT NEEDED.)

NAME OF INSURANCE COMPANY _____

ADDRESS _____

NAME OF INSURED PERSON _____

POLICY NO. _____ CLAIM NO. _____

COMMENTS _____

_____

_____

DIAGNOSIS _____ NAME OF PROVIDER _____

IS TREATMENT COMPLETED _____ YES _____ NO

DATE _____ BY _____

Providers will not be involved in litigation or collection attempts by the Department of Medical Assistance Services nor will reimbursement to the provider be withheld as a result of submitting this form.

PLEASE MAIL TO:

THIRD PARTY LIABILITY/CASUALTY
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 E. BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

DMAS - 1000 R9/87